Basic Medicaid Seminar
April 2007 Seminar Registration Form
(No Fee)

Provider Name_____

Medicaid Provider Number_____NPI Number_____

Mailing Address_____

City, Zip Code_____County_____

Contact Person_____E-mail_____

Telephone Number (____)_____Fax Number_____

1 or 2 person(s) will attend the seminar at _____on_____
(circle one) (location) (date)

Please fax completed form to: 919-851-4014
Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, N.C. 27622